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No. 04-1000

IN THE
Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

SHIRLEY O. FOUGHT,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

MOTION OF AMERICA'S HEALTH INSURANCE PLANS AND THE AMERICAN COUNCIL OF LIFE INSURERS FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* IN SUPPORT OF PETITIONER AND BRIEF *AMICI CURIAE*

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America's Health Insurance Plans ("AHIP") and the American Council of Life Insurers ("ACLI") ("amici") hereby move, pursuant to S. Ct. R. 37.2, for leave to file a brief *amici curiae* in support of the petition for writ of *certiorari* to the Supreme Court of the United States. *Amici* are filing this motion because Respondent has declined to consent to this *amici curiae* brief.[1] A copy of the proposed brief is attached.

As more fully explained at pages 1-3 of the brief under "Interest of *Amici Curiae*," *amici* are trade associations representing members who insure and administer ERISA disability and other benefit plans. They and their membership will suffer the effects of the Tenth Circuit's decision in *Fought v. UNUM Life Insurance Co.*, 379 F.3d 997 (10th Cir. 2004), creating an automatic and irrebuttable presumption of impermissible bias with respect to any benefits decisions made by insurers and other payors of ERISA benefits.

This brief will assist the Court in determining whether to grant *certiorari* because *amici* are uniquely positioned to point out: (1) the importance of this case to all insurers and payors of ERISA plan benefits, including self-funded payors ("Payor Fiduciaries"), not only in the Tenth Circuit, but throughout the United States; (2) the need for this Court to grant *certiorari* in this case in view of the various Circuits' inability to identify and comply with the appropriate standard of deference that should be granted to benefits decisions made by Payor Fiduciaries; (3) the role Payor Fiduciaries play in helping plans administer benefits; (4) Congress' intent in establishing ERISA as a uniform policy for provision of disability benefits; and, most importantly, (5) the harmful impact the Tenth Circuit's decision in *Fought* will have on this nation's voluntary employer-based health care and other benefits systems.

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[1] Upon being contacted by counsel for *amici* on March 29, 2005, counsel for respondent denied his consent for *amici* to file this brief. The letter of consent from the petitioner is being submitted herewith.

Accordingly, *amici* respectfully request that the Court grant leave to file the attached brief *amici curiae*.

Respectfully submitted,

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INTRODUCTION

INTEREST OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") and the American Council of Life Insurers ("ACLI")[1] respectfully submit this brief urging the Court to grant the Petition for a Writ of Certiorari (petition) in this case. Amici support the petition because the application of a proper judicial review standard to benefit coverage decisions made by ERISA fiduciaries who are insurers ("Payor Fiduciaries") is essential to the survival of this nation's voluntary employer-based health care and disability benefits system. The radical review standard devised by the United States Court of Appeals for the Tenth Circuit, that such fiduciaries' judgments respecting the proper interpretation of the Employee Retirement Income Security Act of 1974 ("ERISA") plans' documents are not entitled to either recognition or deference solely because of the purported influence of an economic stake in such decisions, presents a serious threat to the continued viability of that system. 29 U.S.C. § 1001, et seq. (2005); *Fought v. UNUM Life Ins. Co.*, 379 F.3d 997 (10th Cir. 2004)("*Fought*").

AHIP's membership consists of approximately One Thousand Three Hundred (1,300) companies who administer and/or insure benefits including disability, long-term care, supplemental coverage, health, and pharmaceutical coverage to more than 200 million Americans, the very great majority of whom are participants in, or beneficiaries of, employee benefit plans under ERISA. AHIP seeks to facilitate, preserve and increase the availability of affordable benefit coverage related to health care and to disability. AHIP has accumulated substantial knowledge and experience about the proper administration of ERISA plans and the responsibilities of ERISA fiduciaries

[1] Pursuant to Sup. Ct. R. 37.6, ACLI's and AHIP's counsel of record hereby certifies that this brief was authored in whole by Epstein Becker & Green, P.C., and that no individual or entity other than amici curiae AHIP and ACLI have contributed monetarily to the preparation or submission of this brief.

through its members' activities on behalf of employers and other ERISA benefit plan sponsors.

The American Council of Life Insurers ("ACLI") is the largest life insurance trade association in the United States, representing the interests of 354 member legal reserve life insurers operating in the United States. These 354 member companies account for 69 percent of life insurance premiums in the United States among legal reserve life insurance companies, 51 percent of disability income insurance premiums and 79 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of ERISA.

Of substantial concern to *amici* and their members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to actions under ERISA alleging wrongful denial of benefits when an insurer, or any other administrator or fiduciary, is operating under a conflict of interest. *Amici* are uniquely positioned to explain the practical effects of this ongoing conflict upon employer-sponsored benefit plans, and the need for the Court to resolve this conflict.

Amici firmly believe that the standard of judicial review enunciated by the Tenth Circuit in *Fought* will jeopardize the continued sponsorship of ERISA benefit plans by employers and, thus, produce a result directly contrary to that intended by Congress when it enacted ERISA. The Tenth Circuit's decision rests on the undocumented factual assumptions that Payor Fiduciaries, their officers, their employees and their agents are: (a) inherently biased; (b) unable to comply with ERISA's fiduciary standards; and (c) incapable of objective judgment in their interpretation of plan documents governing benefit

coverage criteria. Available data, however, establishes that disability payors approve the overwhelming majority of claims for coverage,[2] and have no hesitancy to overturn their own initial denials when they conclude that their judgment was unsound.[3]

Amici's interest is not limited to the impact of the Tenth Circuit's decision on disability insurers alone. The principal holding of the Tenth Circuit's decision, that payors of benefits are presumptively biased and incapable of reaching legitimate and reasonable interpretations of plan documents, is fully applicable to insurers of ***any*** type of benefit which is offered by ERISA plans. Indeed, the decisional principle announced in *Fought* that "payors" who serve as claim fiduciaries can never be assumed to be capable of objectivity is applicable to employers and trustees of self-funded ERISA benefit plans. Through this brief, AHIP and ACLI not only seek to protect the interest of their members, they seek to protect the interests of ***all*** Payor Fiduciaries.

REASONS WHY THE PETITION SHOULD BE GRANTED

The Petition should be granted because the Tenth Circuit's decision in *Fought* is inconsistent with fundamental purposes and principles of ERISA and the prior rulings of this Court. The ruling in *Fought*, if allowed to stand, threatens the viability of the privately funded, employer-based system of economic protection for: (a) millions of workers who suffer disabling injuries; and (b) millions of workers, retirees and their covered

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[2] For example, "Of the approximate 464,000 new disability claims filed with [UNUM] in 2003, approximately 90% were paid. Of the remainder, approximately one-half were no longer claiming benefits when payments would have begun. Slightly more than 1 percent were determined not to be disabled." UnumProvident Corp., *Our Customer Commitment at Claim Time, at http://www.unumprovident.com/aboutus/ourcompanies/more.aspx#protecting.*

[3] See discussion *infra* pp. 14-15.

dependents who obtain health care coverage through employment.[4] The Tenth Circuit's unprecedented ruling that Payor Fiduciaries vested with the discretion to interpret ERISA plan documents must be presumed to be biased and incapable of forming reasonable interpretations of such documents is directly contrary to this Court's clear ruling that the courts should grant deference to those interpretations. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The *Fought* decision signals that at least one lower court has failed to grasp the instruction of this Court in *Firestone*, or believes that it is free to reject that instruction. If the *Fought* decision is allowed to stand, other courts might reasonably conclude that the teaching of *Firestone* is less definitive and authoritative than the clear text of the Court's opinion. Those courts may very well conclude, as the Tenth Circuit has, that they are free to create their own approaches to the invalidation of plan fiduciaries' benefit coverage decisions, and substitute their own views of the benefits that ERISA plans should cover. That prospect is a substantial deterrent to the willingness of employers to provide ERISA plan benefits of any kind to their employees. Second only to excessive cost, the biggest deterrent to the sponsorship of benefit plans by employers is uncertainty and lack of uniformity with respect to the scope of the benefits they may be obligated to cover and administer.

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[4] The Bureau of Labor Statistics identifies the percentage of workers employed by private industry covered by long term disability ("LTD") benefit programs in 2003 at twenty eight percent (28%) of the workforce, and by short term disability ("STD") benefit programs at about approximately thirty-seven percent (37%). Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2002-2003*, at 7 (Jan. 2005).

ARGUMENT[5]

I. THE VOLUNTARY, PRIVATE DISABILITY COVERAGE SYSTEM VITAL TO THE NATION'S WELL BEING IS JEOPARDIZED BY THE RULING IN THE *FOUGHT* CASE

In 1963, only 3 million people were covered by disability policies. By 1984 there were more than 22 million people with long term disability protection, with 17.3 million covered under group policies and 5.5 million with individual policies. Diane B. Hill, *Employer-Sponsored Long-Term Disability Insurance*, 110 Monthly Lab. Rev. 16 (July 1987), *available at* http://www.bls.gov/opub/mlr/1987/07/art2full.pdf. Currently there are over 33.8 million employees covered by disability policies. JHA, Inc., *The JHA Disability Fact Book*, at 1 (2003/2004 ed.). The number of persons with disability benefits has increased ten-fold since 1963, demonstrating the critical and growing importance of this benefit, and the necessity of avoiding the creation of arbitrary and unhelpful barriers that impair its availability to an aging worker population.

One reason for the increasing growth of and reliance on disability benefit plans is the substantial aging of the workforce caused by so-called "Baby Boomers" (individuals born between 1946 and 1964). This aging factor is important because older workers are five times more likely to submit a disability claim than their younger counterparts.[6] The data show that, for long term disability, workers in the fifty-two to fifty-seven year old

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[5] Amici support all of Petitioner's Arguments but specifically concur in the argument presented in Section IC, at pp. 16-18, of the Petition, respecting the inconsistent interpretation among the lower courts of this Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[6] BenefitNews Connect, *Disability Claims Up As Older Workers Delay Retirement*, (May 15, 2003), *at* http://www.benefitnews.com/detail.cfm?id=4516&terms=|delay||up||older||retirement||workers||claims||disability|.

age cohort submit approximately eighteen claims per thousand, while workers in the twenty-two to twenty-seven year old age cohort only submit about three claims per thousand.[7] The former Health Insurance Association of America, which became a part of AHIP, reported that the Social Security Administration predicts a thirty-seven percent (37%) increase in instances of disability due to the aging workforce.[8]

According to a National Association of Insurance Commissioners ("NAIC") report, approximately 18 % of males and 22% of females, under the age of 45, are likely to become disabled for a period of at least 90 days during their working lives. NAIC, *Commissioner's Individual Disability Table A (1985), in* America's Health Insurance Plans, *Disability Insurance: A Missing Piece in the Financial Security Puzzle* 5 (Oct. 2004). Another study indicates that, before age thirty-five, a worker has a one-in-four chance of becoming disabled for more than ninety days during the rest of his or her working life.[9] Recent data also suggest that one third of all workers between twenty five and sixty will experience an injury or illness that will keep them out of work for three months or longer.[10] Nearly sixty percent of disabling injuries happen off the job and are not covered by Workers' Compensation coverage, but

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[7] JHA, Inc., *Analysis of 1987 GLTD Table*, The JHA Disability Fact Book, at 30 (2003/2004 ed.).

[8] Health Insurance Association of America, *An Employer's Guide to Disability Income Insurance* at 2, *at www.ahip.org./content/default.aspx?bc=41|329|349* (based upon statistics regarding the Risk of Long Term Disability vs. Death for Males as published in the 2001 JHA Disability Fact Book).

[9] Saylor & Hill Co., *A Valuable Product Many Ignore Talking About*, 46 Benefit Plan Developments Online 5, *at* http://www.saylorhill.com/bpdnews/bpd_v46n5.html.

[10] Princeton Research Survey Associates, *Consumer Federation of America* (Feb. 20, 2001).

are covered by most disability plans.[11] In 2003, the Petitioner alone paid four billion, one hundred million dollars ($4,100,000,000) in disability related benefits.[12] This amount of disability benefit payments is inconsistent with the Tenth Circuit's assumption that Payor Fiduciaries typically reach for unjustifiable interpretations of plan documents that will save them the cost of paying benefits.

Private disability plans provide coverage at a rate which greatly exceeds that of public disability programs. Analysis of the Social Security Disability Insurance (SSDI) program has shown that during the first year of disability, approximately forty-one percent (41%) of those individuals who qualify for disability benefits through their private disability insurance plan do not qualify for SSDI benefits.[13] It often takes several years to receive disability benefits through SSDI. In contrast, Department of Labor Regulations governing ERISA disability plans require that an initial determination on disability claims must be made within forty-five days of the plan's receipt of claim.[14]

II. THE *FOUGHT* DECISION IGNORES A FUNDAMENTAL DISTINCTION BETWEEN THE ROLE OF FIDUCIARIES UNDER THE COMMON LAW OF TRUSTS AND THEIR ROLE UNDER ERISA.

In addition to the lack of any factual documentation for the premise that Payor Fiduciaries generally interpret plan documents in a biased manner, the *Fought* decision presents

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[11] Life Insurance Marketing Association (LIMRA), *Trends in U.S. Household Life Insurance Ownership* (2000).

[12] UnumProvident, Corp., *Our Customer Commitment at Claim Time*, *at* http://www.unumprovident.com/aboutus/ourcompanies/more.aspx#protecting.

[13] America's Health Insurance Plans, *Disability Insurance: A Missing Piece in the Financial Security Puzzle*, at 17-23 (Oct. 2004).

[14] 29 C.F.R. § 2560.503-1 (2004).

many other substantive concerns. For example, the Tenth Circuit disregarded an important distinction from the common law of trusts that Congress intentionally crafted in ERISA. Under the common law, fiduciaries could not occupy ***any*** position that placed them in ***any*** conflict with the trusts or beneficiaries with whom they had a fiduciary relationship. In ERISA, Congress created a limited fiduciary status in which an entity or person who might have interests contrary to those of a benefit plan in one setting, nonetheless could serve as a fiduciary to that same plan for another purpose.[15] For example, ERISA provides that a fiduciary role may be assumed by an individual who is an officer, employee, agent or other representative of the employer sponsoring the plan when that employer is funding plan benefits from its own assets.[16]

The paradigm example involves insurance companies which ERISA allows to serve as claims fiduciaries to a benefit plan despite the fact that, when marketing their insurance products to that same plan, they seek to maximize their economic benefit from that transaction.[17] If Congress believed that these

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[15] 29 U.S.C. §1104 (2005).

[16] 29 U.S.C. §1108(c)(3) (2005).

[17] *See, e.g., Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-1110 (9th Cir. 1999) (Court cognizant of insurer's dual role); *Taft v. Equitable Life Assur. Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993) (Where a plan vests the administrator with discretionary authority to determine eligibility for benefits, the court may only review such determination for an abuse of discretion.); *McMahon v. McDowell*, 794 F.2d 100, 110 (3d Cir. 1986) ("ERISA does not absolutely bar a plan fiduciary from simultaneously serving as a director or officer of the employer or of another party in interest."); *Sutton v. Weirton Steel*, 724 F.2d 406, 411 (4th Cir. 1983) ("Congress . . . has not prohibited an employer who is also a fiduciary from exercising the right accorded other employers to renegotiate or amend . . . unfunded contingent benefits payable before normal retirement age."); *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.

(Cont'd)

circumstances were unacceptably prejudicial to plans and their members, it easily could have followed the common law of trust model, but it did not. In *Fought*, the Tenth Circuit does not disclose the basis for its authority as an Article III court to reject the policy decision made by Congress that persons could have multiple relationships with ERISA plans, some of which put them in adversarial positions to those plans, but still serve the same plans as fiduciaries for other purposes.

Critically, Congress did not create different classes of fiduciaries to whom various levels of deference would be due by the courts. Congress did not differentiate between fiduciaries with no conflicts of any kind with the plans they served and those fiduciaries with conflicts in the context of a relationship other than as a fiduciary. The Tenth Circuit nowhere identifies in its decision a source of judicial authority to create classifications of fiduciaries, but acts as if such authority existed. In *Firestone*, this Court did not undertake to engraft onto ERISA new classes of fiduciaries whose interpretations of plan documents were subject to different levels of judicial deference. *Firestone*, 489 U.S. at 111-113. The Court focused on the provisions of ERISA which grant to employers and other benefit plan sponsors a right to design the structure of their plans and, in that context, determine the extent of authority and discretion of the plan fiduciaries to interpret plan documents.[18]

Critically, the Court in *Firestone* decided whether a deferential standard of review of fiduciary decisions was

(Cont'd)

1982) (Transactions under ERISA expressly permit "investment of up to ten percent of the fund assets in securities issued by the employer of the employees who are participants in the plan. Since such an employer will often be an administrator of his plan, or will function as a trustee or in some other fiduciary capacity, this provision creates a limited exception to the listed proscription against self-dealing. The exception is made in recognition of the symbiotic relationship existing between the employer and the plan covering his employees.").

[18] *Firestone*, 489 U.S. at 113-114.

warranted, or not, on the basis of the fiduciaries' authority specified in the plan documents.[19] The Court did not condition the use of the deferential standard of review on whether the fiduciary had any other relationship to a plan that involved self-interest. In *Fought*, the Tenth Circuit rejected the teachings of *Firestone* by asserting the directly contrary proposition that courts may reject a plan sponsor's decision to grant interpretive discretion to Payor Fiduciaries by denying a deferential standard of review to such fiduciaries' interpretations of plan documents. The *Fought* decision also increases the burden of Payor Fiduciaries to justify their interpretations to a level greater than that required in a de novo review by imposing the presumption that Payor Fiduciaries are biased. 379 F.3d at 1003.

III. THE TENTH CIRCUIT'S DECISION UNDERCUTS THE INTENT OF CONGRESS TO ENABLE ERISA PLANS TO PROVIDE UNIFORM BENEFITS TO THEIR MEMBERS AND TO ADMINISTER AND FUND THEIR BENEFITS IN A PREDICTABLE MANNER

A clear intention of Congress in enacting ERISA was to enable employers to offer benefit plans to employees that would be uniformly interpreted and administered in all jurisdictions in which such employees were located.[20] Uniformity of interpretation and administration are critical to a plan sponsor's ability to project its costs in connection with the offering of health and welfare benefit plans. *Id.* The experience of AHIP's and ACLI's members is that predictability of cost is highly important to employers making decisions about what kind of benefit plan, if any, to offer to their employees. Therefore, consistency of interpretation of plan document provisions is critical to plan sponsors.

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[19] *Id.* at 115 .

[20] 29 U.S.C. §§ 1000(b), 1000b(c) (2005); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 127 (1992); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

Fought frustrates employers' need for uniformity and consistency. Under *Fought*, any time that a fiduciary also is a payor, its interpretations of plan documents not only are subject to judicial review, they are subject to a hostile standard of review predisposed to reject those interpretations on the basis of a presumption of bias. This burdensome standard of review has three adverse effects on employers: (1) inviting more costly litigation over the interpretation of plan documents by claimants who believe that the presumption of bias frees them from the burden of asserting a colorably legitimate claim; (2) increasing the cost of such litigation by, at a minimum, shifting the burden of proof to the Payor Fiduciary; and (3) facilitating the ability of courts to substitute their own interpretations of a plan's documents for those of the plan's designated claims fiduciary without regard to the fiduciary's experience, knowledge of the operation of the plan, understanding of the expectations of the participants, or the quality and competence of its performance as a claims fiduciary.

IV. THE PRESUMPTION OF BIAS IN *FOUGHT* IS IRREBUTTABLE AND ALWAYS LEADS TO A STRINGENT AND HIGHLY BURDENSOME STANDARD OF REVIEW

Fought purports to provide Payor Fiduciaries a right to prove their lack of bias, but that right is illusory. The basis for the presumption of bias is the fiduciary's ***status as a payor***. As long as the fiduciary was a payor at the time of its interpretation of the plan document at issue, it cannot prove it was free of bias because, under *Fought*, Payor Fiduciaries are biased by definition. The consequence of a Payor Fiduciary's inability to prove lack of bias is that their plan document interpretations can never be reviewed either under the deferential standard or the de novo standard, but only under some other, presumably harsher and more burdensome, standard.

This understanding of *Fought* is the ***only*** one that makes sense. *Fought* rejects the arbitrary and capricious standard,

holding that biased fiduciaries are not owed any deference. The de novo standard is applicable to fiduciaries who have not been granted the discretion to interpret plan documents and does not address the issue of fiduciaries who may be subject to a conflict in some other relationship to their plan. The Tenth Circuit has concluded that conflicted fiduciaries are irrebuttably biased in their own favor when acting in their capacity as fiduciaries and thus constitute yet a lower class of fiduciary required to bear a greater burden of proof to justify their interpretations. The precise elements of that additional burden are not delineated in the *Fought* decision. What is clear is that Payor Fiduciaries cannot escape being subjected to that burden.

The Tenth Circuit had no basis for its burdensome discrimination against Payor Fiduciaries. The *Fought* opinion does not point to any objective data proving that Payor Fiduciaries typically make unreasonable plan document interpretations for reasons of economic self-interest. Similarly, there is no citation in *Fought* to objective data showing that the frequency with which Payor Fiduciaries interpret plan documents to deny benefits is greater than that of other fiduciaries.

V. THE TENTH CIRCUIT'S DECISION IN *FOUGHT* WRONGLY ASSUMES THAT IT IS IMPROPER FOR A PLAN FIDUCIARY TO CONSIDER BROAD ECONOMIC AND OTHER FACTORS WHEN INTERPRETING PLAN DOCUMENTS

One of the flaws in the ruling of the Tenth Circuit is its implicit assumption that plan document interpretations that do not focus solely on the circumstances of the plan participant whose claim is under consideration are inconsistent with the proper performance of ERISA fiduciary duties. An ERISA fiduciary's duty does not run only to individual plan participants, but is owed to all participants and their beneficiaries in the aggregate. 29 U.S.C. §§ 1104(a)(1), 1104(a)(1)(A), 1104(a)(1)(D); *Barnhart v. UNUM Life Ins. Co.*, 179 F.3d 583,

584 (8th Cir. 1999)(fiduciary obligations of ERISA plan administrator extend to entire plan, not just individual claimants.); *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196, 201 (1st Cir. 1997). Congress' election to create a duty owed to all plan members in the aggregate, rather than to individual participants, reflects a sensible recognition that individual participants have a self-interest in interpretations of plan documents that maximize their ability to obtain coverage of the benefits *they* need.[21] If fiduciaries owed their duty to each participant separately, a uniform approach to benefit coverage would be nearly impossible to achieve.

Thus, as between two facially reasonable plan document interpretations – one which favors the coverage of a participant's specific circumstances at the risk of jeopardizing a plan's ability to cover all likely and expected covered claim demands with available assets, and the other which results in a denial of the particular claim, thereby preserving the plan's ability to pay anticipated claims for covered benefits submitted by the other plan members in the aggregate – the fiduciary's duty would be to choose the interpretation which protects the members in the aggregate. *Barnhart*, 179 F.3d at 589. The circumstance that the fiduciary making the decision is a Payor Fiduciary does not alter either the character of the duty or of the proper choice.

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[21] Unlike the Tenth Circuit, Congress did not equate self-interest with evil motives or a proclivity for improper conduct. Although plan participants are subject to a self-interested approach to plan benefit coverage, Congress nonetheless empowered them to seek relief from benefit denials they believed were not justified. *See* 29 U.S.C.§ 1132 (a) (2005).

VI. THE STANDARD OF REVIEW IN *FOUGHT* IS INCONSISTENT WITH THIS COURT'S RULINGS IN THE *NORD* AND *DAVILA* CASES [22]

Coverage disputes in the context of disability benefit programs focus on whether the claimant is disabled – i.e. is actually unable to perform some defined level of work. *Just the Facts: A Call for Clarification and Simplification of the Eleventh Circuit's Standard of Review for an ERISA Claims Fiduciary's Factual Determinations*, 5 Mealey's Litigation Report: Disability Insurance 13 (Karen Miehle, ed. July 2004) ("The vast majority of disability claims involve factual disputes, not disputes over plan interpretation."). *Fought* effectively makes a treating physician's finding of disability ***the*** determinative coverage decision by rejecting any contrary coverage determination by a Payor Fiduciary as always impermissibly biased. *Fought*, 379 F.3d at 1006.

In *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004), this Court emphasized the substantive distinctions between the roles and obligations of treating physicians and those of physicians acting as medical directors of an ERISA plan. *Id.* at 2501. The Court rejected the proposition that judgments about proper medical treatment and care made by treating physicians should be controlling with respect to benefit coverage determinations. *Id.* at 2502. As directly relevant to the present case, and unlike the Tenth Circuit in *Fought*, the Court was not swayed by arguments that plan medical directors' judgments were affected by the economic stakes their employers had as payors of benefits and should, therefore, be rejected. *Id.* Contrary to the clear ruling in *Davila* that plan medical directors' status as Payor Fiduciaries was not a proper basis for invalidating their coverage determinations, the Tenth Circuit has made that very same status the basis for a presumption of invalidity and impropriety with respect to medical directors' coverage determinations. *Fought*, 379 F.3d at 1015.

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[22] *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004).

Similarly, in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831, 833 (2003), the Court declined to apply the "treating physician rule" to disability coverage provided by ERISA plans on the grounds that the ERISA requirement for full and fair consideration of the employee's claim did not require that the opinions of the employee's treating physicians be given controlling weight. The Court ruled in *Nord* that the standard was unique to the Social Security Disability Program.[23] In a ruling directly applicable to *Fought*, the Court held that the standard was inconsistent with the discretion and deference to be provided to claim fiduciaries under ERISA. The Tenth Circuit's decision in *Fought* is clearly at odds with the Court's prior relevant rulings.

VII. ERISA DRAWS UPON CONTRACT LAW AND CONTRACT CONSTRUCTION PRINCIPLES FOR THE INTERPRETATION OF PLAN DOCUMENTS, AND THE DECISION BELOW IMPROPERLY IGNORES AND SKEWS THAT LAW AND THOSE PRINCIPLES.

ERISA plan documents are contractual in nature and ERISA jurisprudence draws from contract law. ERISA jurisprudence is a blend of the law of trusts and the law of contracts. *See Firestone*, 489 U.S. at 112-113. The Tenth Circuit's decision in *Fought*, however, filters out the contract law elements, and substitutes a reversion to the strict common law of trusts fiduciary principles that Congress rejected in drafting ERISA. In *Fought*, the Tenth Circuit has equated contractual self-interest to a pervasive corrupt motivation that disables a contracting party from being objective and complying with its legal obligations as an ERISA Fiduciary. This equation has no support in ERISA jurisprudence or contract law.

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[23] 20 C.F.R. § 404.1527(d)(2) (2004) (noting that under the **treating physician rule,** opinions of physicians who have treated the claimant receive controlling weight if they are well-supported by medically acceptable clinical and laboratory diagnostic techniques, and are not inconsistent with the other substantial evidence in the case record).

ERISA, as previously demonstrated, was designed by Congress to be a far less rigid and inflexible instrument of fiduciary governance than the common law of trusts with respect to allowing parties to be both fiduciaries to a plan and to have other relationships with that same plan which give rise to conflicts between them. Thus, ERISA is consistent with principles of contract interpretation which do not penalize parties to contracts for having economic self-interests in how those contracts are interpreted.

This is important because it is indisputable that plan participants have a clear economic self-interest in how their plan's documents are interpreted. The participant's interests and those of his advocates - e.g., physicians -define and drive their interpretations of plan documents to obtain the broadest level of benefit coverage possible. *See Nord*, 538 U.S. at 832. Yet, it would be shocking if a court were to rule that participants' self-interest taints them so that they must prove a lack of bias in addition to proving that an interpretation they have proffered is objectively reasonable. There is no precedent for a rule under contract law that a party with an economic interest in a particular contract interpretation should be penalized for having that interest.

Courts ordinarily will not rewrite contracts when there is a dispute as to the meaning of their terms. CORBIN ON CONTRACTS § 24.19. The Tenth Circuit's decision, however, seems to require courts to rewrite plan documents whether they consist of insurance policies or self-funded arrangements. The *Fought* decision mandates that any plan document interpretation proffered by a Payor Fiduciary is suspect and unacceptable unless the irrebuttable presumption of bias is overcome by meeting some undefined higher burden of proof as to the propriety of the interpretation. This holding effectively excises from plan documents provisions granting a Payor Fiduciary the discretionary authority to interpret those documents by prohibiting the application of the deferential standard of review

attendant to that authority. The *Fought* decision is a clear example of judicial rewriting of insurance and other plan benefit documents to accommodate a particular court's policy view of the appropriate scope of benefit coverages. E. Haavi Morreim, *Benefits Decisions In ERISA Plans: Diminishing Deference To Fiduciaries and An Emerging Problem For Provider-Sponsored Organizations*, 65 Tenn. L. Rev. 511, 516 (1998)("In some of these cases, judges' contract interpretations strain so hard to favor the pleading plaintiff that some commentators have criticized their decisions as 'judge-made insurance.'"). By nullifying clauses that empower Payor Fiduciaries to have their interpretations reviewed under an arbitrary and capricous standard, the Tenth Circuit has freed the courts to substitue their own interpretations.

VIII. THE MARKET WILL PUNISH INSURERS WHO UNJUSTIFIABLY DENY CLAIMS

The assumption that a fiduciary who is also an insurer is likely to err on the side of denying benefits ignores the realities of both the employer-employee relationship and the insurance market. These realities have been recognized by several courts:

> It is a poor business decision to resist paying meritorious claims for benefits. Companies . . . that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans . . . these employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to

> leave and by damaging its chances of acquiring new customers.[24]

In making benefit coverage decisions, business and competitive forces compel insurers to act reasonably. "Affirming reasonable claim determinations in an expeditious fashion achieves ERISA's competing goals of paying benefits and making the cost of coverage more affordable, for the benefit of all. . . .We would not be successful if our policyholders concluded we were treating their employees unfairly."[25] The quality and quantity of services offered by insurers affects how well they fare against competitors. An important goal for employers in paying for benefits is to maintain a satisfied and motivated workforce. Group insurance purchasers typically are sophisticated and base their purchasing decision more on price and service considerations than any other factors. *Marketing Life and Health Insurance* 190 (Nancy E. Strickler ed., 1981). If an insurer is perceived as engaging in unreasonable denials of coverage, its clients will not continue to do business with that insurer.

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[24] *Mers v. Marriott Int'l. Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *see also Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (an insurance carrier "can hardly sell policies if it is too severe in administering them"); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998) ("an employer would not want to keep an overly tight-fisted insurer" and therefore "the conflict is not as serious as might appear at first blush").

[25] Testimony of Lawrence Frank, Standard Insurance Company, Before the Health and Managed Care (B) Committee and Consumer Protections (EX) Working Group of the National Association of Insurance Commissioners (June 14, 2004).

IX. THE EXTREME STANDARD OF REVIEW IMPOSED BY THE TENTH CIRCUIT IS A COSTLY BURDEN THAT IS UNNECESSARY GIVEN THE SAFEGUARDS AGAINST FIDUCIARY ABUSE PROVIDED BY ERISA.

The current standards of judicial review have not been demonstrated to allow fiduciaries to act in disregard of their extensive fiduciary obligations, or in violation of the fiduciary self-dealing prohibitions of ERISA Section 406(b).[26] Fiduciaries are subject to extensive duties and prohibitions against fiduciary self-dealing as set out in ERISA. *See, e.g.*, 29 U.S.C. §§ 1104 and 1106(b) (2005). They may be held personally liable not only for their own conduct that violates their obligations under the statute, but also for failing to prevent or to take action against other fiduciaries who are committing or have committed fiduciary breaches.[27] Fiduciaries who self-deal in violation of Section 406(b) are subject to substantial fines and penalties by the Secretary of Labor. *Id.* § 1132.

From a commercial perspective, insurers and other Payor Fiduciaries who intentionally violate their duties under ERISA run a risk that they may be barred, or enjoined, from serving as ERISA fiduciaries to any ERISA plans, or even from engaging in transactions with ERISA plans. Any such consequence would be financially devastating. The Tenth Circuit's presumption of bias adds little, if any, additional deterrent effect. This is so because ***the Fought standard of review is based on fiduciary status, not fiduciary conduct.*** A Payor Fiduciary whose conduct has conformed in all respects to ERISA's fiduciary standards nonetheless remains subject to that punitive standard of review. A Payor Fiduciary who has violated ERISA's fiduciary standards is not subject to any adverse consequences under *Fought*.

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[26] 29 U.S.C. § 1106(b) (2005).

[27] *See, e.g.*, 29 U.S.C. §§ 1109 and 1132(a)(3) (2005).

X. CONCLUSION

For all of the foregoing reasons, the petition should be granted.

Respectfully submitted,

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